Personal Care Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Personal Care Hours Per Week: _____ **Does the student receive 1:1 services during their entire school week?** _____

Provider Information

Provider Name: _____ **Provider Title:** _____

Supervisory Union: _____ **Name of School:** _____

The student's current IEP requires full-time 1:1 personal care services.

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT**.

Month _____ Year _____ Month _____ Year _____

Use this set of dates for a two-month billing period

1	**2**	**3**	**4**	**5**	**6**	**7**		**1**	**2**	**3**	**4**	**5**	**6**	**7**
8	**9**	**10**	**11**	**12**	**13**	**14**		**8**	**9**	**10**	**11**	**12**	**13**	**14**
15	**16**	**17**	**18**	**19**	**20**	**21**		**15**	**16**	**17**	**18**	**19**	**20**	**21**
22	**23**	**24**	**25**	**26**	**27**	**28**		**22**	**23**	**24**	**25**	**26**	**27**	**28**
29	**30**	**31**						**29**	**30**	**31**				

Total hours personal care was provided during the billing period _____ **hours**

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

1. ☐ **Assistance w/Eating** **5.** ☐ **Behavior Management** **9.** ☐ **Assistive Devices**

2. ☐ **Assistance w/Toileting** **6.** ☐ **Signing/Interpreting** **10.** ☐ **Other:** _____

3. ☐ **Assistance w/Dressing** **7.** ☐ **Medication Admin.** _____

4. ☐ **Assistance w/Hygiene** **8.** ☐ **Mobility/Safety** _____

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____